

Facility Name & ID Number Kewanee Care Home# 0026518 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>27</u>	Skilled (SNF)	<u>27</u>	<u>9,882</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>57</u>	Intermediate (ICF)	<u>57</u>	<u>20,862</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>84</u>	TOTALS	<u>84</u>	<u>30,744</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>3,950</u>	<u>3,950</u>	8
9	SNF/PED					9
10	ICF	<u>14,719</u>	<u>7,280</u>		<u>21,999</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,719</u>	<u>7,280</u>	<u>3,950</u>	<u>25,949</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 84.40%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 06/01/76

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date N/ANO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 11 and days of care provided 3,950Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Kewanee Care Home

0026518

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	107,395	11,387	1,258	120,040		120,040	5,651	125,691			1
2	Food Purchase		125,509		125,509		125,509	(5,400)	120,109			2
3	Housekeeping	65,899	8,500		74,399		74,399	24	74,423			3
4	Laundry	58,867	7,859		66,726		66,726		66,726			4
5	Heat and Other Utilities			73,521	73,521		73,521	513	74,034			5
6	Maintenance	37,781	39,862	2,514	80,157		80,157	3,529	83,686			6
7	Other (specify):* Allocated Benefits							1,011	1,011			7
8	TOTAL General Services	269,942	193,117	77,293	540,352		540,352	5,328	545,680			8
	B. Health Care and Programs											
9	Medical Director			10,100	10,100		10,100		10,100			9
10	Nursing and Medical Records	881,475	77,527	400	959,402		959,402	12,414	971,816			10
10a	Therapy	88,703	597	7,084	96,384		96,384	5	96,389			10a
11	Activities	57,406	1,503	1,332	60,241		60,241	(1,327)	58,914			11
12	Social Services	27,338			27,338		27,338		27,338			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Allocated Benefits							1,199	1,199			15
16	TOTAL Health Care and Programs	1,054,922	79,627	18,916	1,153,465		1,153,465	12,291	1,165,756			16
	C. General Administration											
17	Administrative	80,107		231,027	311,134		311,134	(161,692)	149,442			17
18	Directors Fees											18
19	Professional Services			21,224	21,224		21,224	12,524	33,748			19
20	Dues, Fees, Subscriptions & Promotions			2,664	2,664		2,664	(203)	2,461			20
21	Clerical & General Office Expenses	20,225	7,755	14,841	42,821		42,821	42,194	85,015			21
22	Employee Benefits & Payroll Taxes			233,942	233,942		233,942		233,942			22
23	Inservice Training & Education			5,763	5,763		5,763	714	6,477			23
24	Travel and Seminar			710	710		710	1,517	2,227			24
25	Other Admin. Staff Transportation			9,956	9,956		9,956	2,915	12,871			25
26	Insurance-Prop.Liab.Malpractice			54,300	54,300		54,300	1,020	55,320			26
27	Other (specify):* Allocated Benefits							11,761	11,761			27
28	TOTAL General Administration	100,332	7,755	574,427	682,514		682,514	(89,250)	593,264			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,425,196	280,499	670,636	2,376,331		2,376,331	(71,631)	2,304,700			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Kewanee Care Home

#0026518

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	D. Ownership											30
	Depreciation			82,784	82,784		82,784	19,491	102,275			
31	Amortization of Pre-Op. & Org.											31
32	Interest			134,449	134,449		134,449	5,739	140,188			32
33	Real Estate Taxes			32,680	32,680		32,680	375	33,055			33
34	Rent-Facility & Grounds							2,925	2,925			34
35	Rent-Equipment & Vehicles			1,728	1,728		1,728	102	1,830			35
36	Other (specify):*											36
37	TOTAL Ownership			251,641	251,641		251,641	28,632	280,273			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,835		57,835		57,835		57,835			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			46,116	46,116		46,116		46,116			42
43	Other (specify):* Nonallowable Costs			36,062	36,062		36,062	(36,062)				43
44	TOTAL Special Cost Centers		57,835	82,178	140,013		140,013	(36,062)	103,951			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,425,196	338,334	1,004,455	2,767,985		2,767,985	(79,061)	2,688,924			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(4,202)	2		4
5 Telephone, TV & Radio in Resident Rooms	(5,947)	43		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	14,440	30		9
10 Interest and Other Investment Income	(33)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(1,086)	43		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties	(1,561)	43		18
19 Entertainment				19
20 Contributions	(4,868)	43		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	115	43		24
25 Fund Raising, Advertising and Promotional	(8,761)	43		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See PG 5A	(17,894)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (29,797)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(49,264)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (49,264)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (79,061)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Kewanee Care HomeID# 0026518Report Period Beginning: 01/01/04Ending: 12/31/04

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending income offset	(1,200)	2	1
2	Medicare lab expense	(7,378)	43	2
3	Medicare Xray	(6,576)	43	3
4	Resident flowers	(647)	21	4
5	Special events	(1,332)	11	5
6	Chamber of Commerce & Rotary dues & expenses	(761)	20	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
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30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(17,894)		49

SEE ACCOUNTANTS' COMPILATION REPORT

Kewanee Care Home
Provider #: 0026518
01/01/04 to 12/31/04

Schedule 5A

VI. Adjustment Detail
Line 29 - Other

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Kewanee Care Home

0026518

Report Period Beginning:

01/01/04

Ending:

12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	5,651	0	0	0	0	0	0	0	0	0	5,651	1
2	Food Purchase	(5,402)	2	0	0	0	0	0	0	0	0	0	(5,400)	2
3	Housekeeping	0	24	0	0	0	0	0	0	0	0	0	24	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	513	0	0	0	0	0	0	0	0	0	513	5
6	Maintenance	0	3,529	0	0	0	0	0	0	0	0	0	3,529	6
7	Other (specify):*	0	1,011	0	0	0	0	0	0	0	0	0	1,011	7
8	TOTAL General Services	(5,402)	10,730	0	0	0	0	0	0	0	0	0	5,328	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	12,414	0	0	0	0	0	0	0	0	0	12,414	10
10a	Therapy	0	5	0	0	0	0	0	0	0	0	0	5	10a
11	Activities	(1,332)	5	0	0	0	0	0	0	0	0	0	(1,327)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,199	0	0	0	0	0	0	0	0	0	1,199	15
16	TOTAL Health Care and Programs	(1,332)	13,623	0	0	0	0	0	0	0	0	0	12,291	16
	C. General Administration													
17	Administrative	0	(161,692)	0	0	0	0	0	0	0	0	0	(161,692)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,524	0	0	0	0	0	0	0	0	0	12,524	19
20	Fees, Subscriptions & Promotions	(761)	558	0	0	0	0	0	0	0	0	0	(203)	20
21	Clerical & General Office Expenses	(647)	0	42,841	0	0	0	0	0	0	0	0	42,194	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	714	0	0	0	0	0	0	0	0	714	23
24	Travel and Seminar	0	0	1,517	0	0	0	0	0	0	0	0	1,517	24
25	Other Admin. Staff Transportation	0	0	2,915	0	0	0	0	0	0	0	0	2,915	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,020	0	0	0	0	0	0	0	0	1,020	26
27	Other (specify):*	0	0	11,761	0	0	0	0	0	0	0	0	11,761	27
28	TOTAL General Administration	(1,408)	(148,610)	60,768	0	0	0	0	0	0	0	0	(89,250)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,142)	(124,257)	60,768	0	0	0	0	0	0	0	0	(71,631)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Kewanee Care Home# 0026518

Report Period Beginning:

01/01/04

Ending:

12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	14,440	0	5,051	0	0	0	0	0	0	0	0	19,491	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(33)	0	5,772	0	0	0	0	0	0	0	0	5,739	32
33	Real Estate Taxes	0	0	375	0	0	0	0	0	0	0	0	375	33
34	Rent-Facility & Grounds	0	0	2,925	0	0	0	0	0	0	0	0	2,925	34
35	Rent-Equipment & Vehicles	0	0	102	0	0	0	0	0	0	0	0	102	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	14,407	0	14,225	0	0	0	0	0	0	0	0	28,632	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(36,062)	0	0	0	0	0	0	0	0	0	0	(36,062)	43
44	TOTAL Special Cost Centers	(36,062)	0	0	0	0	0	0	0	0	0	0	(36,062)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(29,797)	(124,257)	74,993	0	0	0	0	0	0	0	0	(79,061)	45

Facility Name & ID Number Kewanee Care Home# 0026518

Report Period Beginning:

01/01/04

Ending:

12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See attached Schedule 6A		See attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 5,651	\$ 5,651 1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	2	2 2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	24	24 3
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	513	513 4
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,529	3,529 5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,011	1,011 6
7	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	12,414	12,414 7
8	V	10A Therapy		Petersen Health Care, Inc.	100.00%	5	5 8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	5	5 9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,199	1,199 10
11	V	17 Administrative	231,027	Petersen Health Care, Inc.	100.00%	69,335	(161,692) 11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	12,524	12,524 12
13	V	20 Dues, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	558	558 13
14	Total		\$ 231,027			\$ 106,770	\$ * (124,257) 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Kewanee Care Home** # **0026518** Report Period Beginning: **01/01/04** Ending: **12/31/04**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 42,841	\$ 42,841
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	714	714
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	1,517	1,517
18	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,915	2,915
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	1,020	1,020
20	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	11,761	11,761
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	5,051	5,051
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	5,772	5,772
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	375	375
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	2,925	2,925
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	102	102
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 74,993	\$ * 74,993

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Kewanee Care Home
0026518
12/31/2004

Schedule 6A

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

Arcola Health Care Center	Arcola, IL
Bement Health Care Center	Bement, IL
Casey Health Care Center	Casey, IL
Countryview Terrace	Louisville, IL
Eastview Terrace	Sullivan, IL
El Paso Health Care Center	El Paso, IL
Flora Health Care Center	Flora, IL
Havana Health Care Center	Havana, IL
Kewanee Care Home	Kewanee, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie Rose Health Care Center	Pana, IL
Robings Manor Nursing Home	Brighton, IL
Royal Oaks Care Center	Kewanee, IL
Sheldon Health Care Center	Sheldon, IL
Sullivan Health Care Center	Sullivan, IL
Sunset Manor Nursing Home	Canton, IL
Tuscola Health Care Center	Tuscola, IL

Out-of-State:

Meadow Lawn Nursing Center	Davenport, IA
----------------------------	---------------

Related Assisted Living

Kewanee Courtyard Estates	Kewanee, IL
Kewanee Courtyard Village	Kewanee, IL
Monmouth Courtyard Estates	Monmouth, IL

Other Related Business Entities

Petersen Health Care, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Health Care II, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Enterprises	Peoria, IL	Management/Bookkeeping
Petersen Health Systems	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	1,023,654	3	6.00	Salary	\$ 69,335	L17, C8	1
2											2
3											3
4											4
5											5
6		See attached Schedule 7A									6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 69,335		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Kewanee Care Home
0026518
12/31/2004

Schedule 7A

VII. Related Parties

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

Name	Arcola Health Care Center	Bement Health Care Center	Casey Health Care Center	Countryview Terrace	Eastview Terrace	El Paso Health Care Center	Flora Health Care Center	Havana Health Care Center	Kewanee Care Center	Meadow Lawn Nursing Center	Palm Terrace of Mattoon	Prairie Rose Health Care Center	Robings Manor Nursing Home	Royal Oaks Care Center	Sheldon Health Care Center	Sullivan Health Care Center	Sunset Manor Nursing Home	Tuscola Health Care Center	TOTAL
Mark Petersen	90,072	55,013	25,865	15,145	58,361	74,717	10,659	72,956	69,335	54,095	111,582	77,674	64,047	91,387	33,271	68,050	101,105	19,655	1,092,989

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Kewanee Care Home**# **0026518**

Report Period Beginning:

01/01/04

Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Petersen Health Care Companies

Street Address

7218 North Villa Lake

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	409,056	18	\$ 89,079	\$ 89,071	25,949	\$ 5,651	1
2	2	Food	Patient Days	409,056	18	33		25,949	2	2
3	3	Housekeeping	Patient Days	409,056	18	372		25,949	24	3
4	5	Utilities	Patient Days	409,056	18	8,082		25,949	513	4
5	6	Maintenance	Patient Days	409,056	18	55,644	49,773	25,949	3,530	5
6	7	Mgmt. Allocation of Benefits	Patient Days	409,056	18	15,931		25,949	1,011	6
7	10	Nursing and Medical Records	Patient Days	409,056	18	195,694	164,789	25,949	12,414	7
8	10A	Therapy	Patient Days	409,056	18	75		25,949	5	8
9	11	Activities	Patient Days	409,056	18	86		25,949	5	9
10	15	Mgmt. Allocation of Benefits	Patient Days	409,056	18	18,908		25,949	1,199	10
11	17	Administrative	Patient Days	409,056	18	1,092,989	1,092,989	25,949	69,335	11
12	19	Professional Services	Patient Days	409,056	18	197,418		25,949	12,523	12
13	20	Dues, Fees, Subs & Promos	Patient Days	409,056	18	8,792		25,949	558	13
14	21	Clerical & General Office	Patient Days	409,056	18	675,343	522,789	25,949	42,841	14
15	23	Inservice Training & Education	Patient Days	409,056	18	11,260		25,949	714	15
16	24	Travel and Seminar	Patient Days	409,056	18	23,910		25,949	1,517	16
17	25	Other Admin. Staff Transport.	Patient Days	409,056	18	45,949		25,949	2,915	17
18	26	Insurance-Prop.Liab.Mal.	Patient Days	409,056	18	16,073		25,949	1,020	18
19	27	Mgmt. Allocation of Benefits	Patient Days	409,056	18	185,395		25,949	11,761	19
20	30	Depreciation	Patient Days	409,056	18	79,620		25,949	5,051	20
21	32	Interest	Patient Days	409,056	18	90,987		25,949	5,772	21
22	33	Real Estate Taxes	Patient Days	409,056	18	5,910		25,949	375	22
23	34	Rent - Facility & Grounds	Patient Days	409,056	18	46,102		25,949	2,925	23
24	35	Rent - Equipment & Vehicles	Patient Days	409,056	18	1,612		25,949	102	24
25	TOTALS					\$ 2,865,264	\$ 1,919,411		\$ 181,763	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kewanee Care Home# 0026518

Report Period Beginning:

01/01/04

Ending:

12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Interest Expense	10
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	First Bank		X	Van	\$722.00	9/30/02	\$ 43,315	\$ 21,709	09/01/07	0.0862	\$ 4,092	1
2	LaSalle Bank		X	Mortgage	\$2,465+Int.	08/31/02	2,276,498	2,202,986	08/31/07	varies	123,901	2
3												3
4												4
5												5
	Working Capital											
6	LaSalle Bank		X	Line of Credit	interest only	8/31/03	1,000,000	600,000	8/31/05	0.0450	6,456	6
7												7
8												8
9	TOTAL Facility Related				\$722.00		\$ 3,319,813	\$ 2,824,695			\$ 134,449	9
	B. Non-Facility Related*											
10								Home office allocation			5,772	10
11												11
12												12
13								Less: Interest income offset			(33)	13
14	TOTAL Non-Facility Related						\$	\$			\$ 5,739	14
15	TOTALS (line 9+line14)						\$ 3,319,813	\$ 2,824,695			\$ 140,188	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Kewanee Care Home**# **0026518** Report Period Beginning: **01/01/04** Ending: **12/31/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																											
1. Real Estate Tax accrual used on 2003 report.		\$ 9,500	1																								
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	\$ 21,080	2																								
3. Under or (over) accrual (line 2 minus line 1).		\$ 11,580	3																								
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 21,100	4																								
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																								
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.	Home Office Allocation	375																									
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																								
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 33,055	7																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1999</td><td>9,150</td><td>8</td></tr> <tr><td>2000</td><td>9,412</td><td>9</td></tr> <tr><td>2001</td><td>8,888</td><td>10</td></tr> <tr><td>2002</td><td>9,670</td><td>11</td></tr> <tr><td>2003</td><td>21,080</td><td>12</td></tr> </table>	1999	9,150	8	2000	9,412	9	2001	8,888	10	2002	9,670	11	2003	21,080	12	<table border="1"> <tr><td colspan="2">FOR OHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2003 \$</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td></tr> </table>	FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2003 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
1999	9,150	8																									
2000	9,412	9																									
2001	8,888	10																									
2002	9,670	11																									
2003	21,080	12																									
FOR OHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2003 \$																										
14	PLUS APPEAL COST FROM LINE 5 \$																										
15	LESS REFUND FROM LINE 6 \$																										
16	AMOUNT TO USE FOR RATE CALCULATION \$																										
The 2003 Real Estate Tax Bill = \$21,080																											
Estimated Accrual for 2004 = \$21,100																											

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Kewanee Care Home COUNTY Henry

FACILITY IDPH LICENSE NUMBER 0026518

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2. <u>25-05-281-017</u>	<u>901 W. Mill Street</u>	\$ <u>94.12</u>	\$ <u>94.12</u>
3. <u>25-04-151-009</u>	<u>144 Junior Avenue</u>	\$ <u>20,914.48</u>	\$ <u>20,914.48</u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u>25-04-152-001</u>	<u>821 Dewey Avenue</u>	\$ <u>71.36</u>	\$ <u>71.36</u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u>21,079.96</u>	\$ <u>21,079.96</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

A. Square Feet:

12,548

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

One

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized:

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	42,000	1976	\$ 25,000	1
2	Facility	11,250	1992	25,621	2
3	TOTALS	53,250		\$ 50,621	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kewanee Care Home

0026518

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	65	1976		\$ 381,128	\$	30	\$ 12,704	\$ 12,704	\$ 370,811
5	11	1998		753,696	19,325	40	18,842	(483)	124,043
6	8	2002		672,751	17,417	40	8,409	(9,008)	16,818
7									
8									
Improvement Type**									
9	Various	1984		14,365		30	479	479	9,613
10	Various	1985		7,400	237	10		(237)	7,400
11	Various	1987		10,278	326	10-15		(326)	10,278
12	Various	1988		14,958	476	10-15		(476)	14,958
13	Various	1989		1,900	60	15	40	(20)	1,900
14	Various	1991		8,793	279	15	586	307	8,061
15	Various	1992		16,898	536	12	119	(417)	16,898
16	Various	1993		4,962	207	10		(207)	4,962
17	Various	1994		22,158	568	15	1,477	909	14,894
18	Various	1995		31,243	956	20	1,562	606	14,876
19	Tile Flooring	1996		1,083	28	20	54	26	477
20	Curtains Custom	1996		1,275		20	64	64	555
21	Emergency Light	1996		304		20	15	15	130
22	Fire Alarm	1996		2,099		20	105	105	910
23	Tile Flooring	1996		1,287	33	20	64	31	549
24	Boiler	1996		2,996	77	20	150	73	1,238
25	Water Heater Repair	1996		1,010		20	51	51	455
26	Ceiling Repairs	1996		2,117		20	106	106	945
27	Piping Repairs	1996		855		20	43	43	383
28	Fire Alarm	1996		1,331		20	67	67	547
29	Fire System	1996		1,564		20	78	78	657
30	Landscaping	1996		9,815		20	491	491	4,214
31	Landscaping	1996		1,986		20	99	99	825
32	Chrome Door Knob	1996		72		20	4	4	35
33	Emergency Light	1996		182		20	9	9	81
34	Painting	1996		672		20	34	34	300
35	Floor Tile	1997		8,472	217	20	424	207	3,321
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Kewanee Care Home

0026518

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Storage Shed	1997	\$ 10,177	\$ 261	20	\$ 509	\$ 248	\$ 3,775	37	
38	Windows	1997	5,136	132	20	257	125	1,929	38	
39	Ceiling Repairs	1997	8,291	213	20	415	202	3,043	39	
40	Landscaping	1997	8,085	487	20	404	(83)	2,929	40	
41	Landscaping	1997	1,298	78	20	65	(13)	471	41	
42	Whirlpool	1997	9,343	240	20	467	227	3,308	42	
43	Boiler	1997	3,000	77	20	150	73	1,075	43	
44	Wing Additions	1997	3,700	95	20	185	90	1,310	44	
45	Attic Piping	1997	3,318		20	166	166	1,231	45	
46	Compressor	1997	809		20	40	40	283	46	
47	Fire Alarm	1997	2,338		20	117	117	897	47	
48	Code Alert Receiver	1997	1,863		20	93	93	713	48	
49	New sign	1998	7,304	652	20	730	78	4,745	49	
50	Landscaping	1998	21,500	1,324	20	1,075	(249)	7,167	50	
51	Duct Work-New Wing	1999	1,494	38	20	75	37	412	51	
52	Tiling	1999	914	23	20	46	23	253	52	
53	Water Heater	1999	2,835	253	20	142	(111)	781	53	
54	Water Heater	1999	3,766	336	20	188	(148)	1,034	54	
55	Cubicle Partitions	1999	701	63	20	35	(28)	192	55	
56	Beauty Salon	2000	943	24	20	47	23	212	56	
57	Tile Flooring	2000	10,294	264	20	515	251	2,317	57	
58	Lot/House Razed	2000	21,237	1,529	20	1,062	(467)	4,779	58	
59	Concrete	2001	900	69	15	60	(9)	240	59	
60	Landscaping	2001	1,045	56	15	70	14	281	60	
61	Lighting	2001	3,438	88	39	88		352	61	
62	Blinds/Curtains	2001	9,500	1,187	7	1,357	170	5,428	62	
63	Landscaping	2002	24,614	631	15	1,641	1,010	4,102	63	
64	Landscaping	2002	4,075	244	15	272	28	680	64	
65	Architectural	2002	21,778	558	20	1,089	531	2,722	65	
66	Carpeting	2002	2,551	65	20	128	63	320	66	
67	Fire System	2002	4,677		20	234	234	585	67	
68	Landscaping	2003	4,899	326	15	327	1	490	68	
69	Simplex Time Clock	2004	3,198	10	10	160	150	160	69	
70	TOTAL (lines 4 thru 69)		\$ 2,186,671	\$ 50,065		\$ 58,285	\$ 8,220	\$ 689,350	70	

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued) B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward	\$ 2,186,671	\$ 50,065		\$ 58,285	\$ 8,220	\$ 689,350	1
2	Air Conditioner	2004	2,700	386	135	(251)	135	2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,189,371	\$ 50,451		\$ 58,420	\$ 7,969	\$ 689,485	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Kewanee Care Home

0026518

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 285,143	\$ 24,287	\$ 30,634	\$ 6,347	10	\$ 138,976	71
72	Current Year Purchases	16,099	2,400	1,152	(1,248)	10	1,152	72
73	Fully Depreciated Assets	107,989					107,989	73
74	Home Office Allocation			5,051	5,051			74
75	TOTALS	\$ 409,231	\$ 26,687	\$ 36,837	\$ 10,150		\$ 248,117	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1997 Dodge Caravan	1998	\$ 32,369	\$ 1,775	\$	(1,775)	4	\$ 32,369	76
77	Facility	2000 Town & Country	2002	35,088	2,950	7,018	4,068	5	17,545	77
78										78
79										79
80	TOTALS			\$ 67,457	\$ 4,725	\$ 7,018	\$ 2,293		\$ 49,914	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,716,680	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 81,863	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 102,275	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 20,412	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 987,516	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6		<u>Allocated from home office</u>			<u>2,925</u>			6
7	TOTAL				\$ <u>2,925</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

N/A
N/A

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 1,830 Description: Copier - 1728; Home Office Allocation - 102

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18		<u>N/A</u>			18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	10A(1)	4064 hrs	\$ 88,703		\$
2	Licensed Speech and Language Development Therapist	10A(3)	hrs			114	5,678		114	5,678	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10A(2), (3)	hrs			28	1,406	597	28	2,003	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39(2)	# of prescripts					52,328		52,328	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): Oxygen	39(2)						5,507		5,507	13
14	TOTAL			\$ 88,703		142	\$ 7,084	\$ 58,432	4,206	\$ 154,219	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Kewanee Care Home
Provider #: 0026518
01/01/04 to 12/31/04

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

<u>Service</u>	<u>Line Reference</u>	<u>Outside Practioner Units</u>	<u>Cost</u>	<u>Supplies</u>
----------------	---------------------------	-------------------------------------	-------------	-----------------

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Kewanee Care Home

0026518

Report Period Beginning: 01/01/04

Ending:

12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/04

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 6,334,340	\$ 6,334,340	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -0-)	427,549	427,549	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,424	3,424	7
8	Accounts Receivable (owners or related parties)	(4,690)	(4,690)	8
9	Other(specify): See Schedule 17A	961,855	961,855	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,722,478	\$ 7,722,478	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	151,595	50,621	13
14	Buildings, at Historical Cost	2,095,231	2,189,371	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	510,963	476,688	16
17	Accumulated Depreciation (book methods)	(1,090,417)	(987,516)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,667,372	\$ 1,729,164	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,389,850	\$ 9,451,642	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,475,147	\$ 3,475,147	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,500	64,500	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,100	21,100	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	71,554	71,554	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,632,301	\$ 3,632,301	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	21,709	21,709	39
40	Mortgage Payable	2,802,986	2,802,986	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,824,695	\$ 2,824,695	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,456,996	\$ 6,456,996	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,932,854	\$ 2,994,646	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,389,850	\$ 9,451,642	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Kewanee Care Home
Provider #: 0026518
01/01/04 to 12/31/04

Schedule 17A

XV. Balance Sheet

Line 9 - Other

Due from Related Party	960,271
Employee Education Loans	<u>1,584</u>

961,855

Line 36 - Other Current Liabilities

Accrued vacation	60,913
Other accrued expenses	<u>10,641</u>

71,554

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,325,865	1
2	Restatements (describe):		2
3	Prior period adjustment	62,600	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,388,465	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	544,389	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 544,389	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,932,854	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Kewanee Care Home

0026518

Report Period Beginning: 01/01/04

Ending:

12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,620,353	1
2	Discounts and Allowances for all Levels	10,227	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,630,580	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	429,518	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 429,518	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,202	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	142,571	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	97,225	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 243,998	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	33	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 33	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	8,245	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,245	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,312,374	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	540,352	31
32	Health Care	1,153,465	32
33	General Administration	682,514	33
B. Capital Expense			
34	Ownership	251,641	34
C. Ancillary Expense			
35	Special Cost Centers	93,897	35
36	Provider Participation Fee	46,116	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,767,985	40
41	Income before Income Taxes (line 30 minus line 40)**	544,389	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 544,389	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
Entity is a cash basis taxpayer.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Kewanee Care Home
Provider #: 0026518
01/01/04 to 12/31/04

Schedule 19A

XVII. Income Statement

Line 26 - Other Revenue	
Transportation revenue	811
Vending commissions	1,200
Restitution	2,000
Prior year coinsurance	379
Billing corrections from prior year	2,618
Audit adjustment	500
Miscellaneous revenue	<u>737</u>
	<u><u>8,245</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kewanee Care Home

0026518

Report Period Beginning: 01/01/04

Ending:

12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,213	1,213	\$ 27,326	\$ 22.53	1
2	Assistant Director of Nursing	921	922	17,412	18.89	2
3	Registered Nurses	188	204	3,673	18.00	3
4	Licensed Practical Nurses	18,080	19,001	283,328	14.91	4
5	Nurse Aides & Orderlies	50,505	52,315	464,069	8.87	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,064	4,064	88,703	21.83	7
8	Rehab/Therapy Aides	1,958	1,958	36,107	18.44	8
9	Activity Director	4,057	4,145	43,444	10.48	9
10	Activity Assistants	1,909	2,034	13,962	6.86	10
11	Social Service Workers	2,014	2,086	27,338	13.11	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	19,416	9.33	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,942	12,195	87,979	7.21	15
16	Dishwashers					16
17	Maintenance Workers	3,117	3,217	37,781	11.74	17
18	Housekeepers	9,606	9,859	65,899	6.68	18
19	Laundry	7,500	7,728	58,867	7.62	19
20	Administrator	2,080	2,080	80,107	38.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,077	2,165	20,225	9.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Plans	2,080	2,080	49,560	23.83	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,391	129,346	\$ 1,425,196 *	\$ 11.02	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	10,100	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	400	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 10,500		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Kewanee Care Home
Provider #: 0026518
01/01/04 to 12/31/04

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32 - Other health Care Wages

<u>Description</u>	<u>Hours</u> <u>Worked</u>	<u>Hours</u> <u>Paid</u>	<u>Salary</u> <u>& Wages</u>	<u>Ave. Hrly.</u> <u>Wages</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kewanee Care Home

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount
Jifi Jacob	Administrator	0%	\$ 80,107	Workers' Compensation Insurance		\$ 54,834	IDPH License Fee		\$
				Unemployment Compensation Insurance		21,576	Advertising: Employee Recruitment		
				FICA Taxes		106,274	Health Care Worker Background Check (Indicate # of checks performed <u>66</u>)		787
				Employee Health Insurance		42,829	Miscellaneous Licenses & Permits		666
				Employee Meals			Miscellaneous Dues		1,211
				Illinois Municipal Retirement Fund (IMRF)*					
				Life Insurance		407			
				Employee Relations		4,748	Allocated from Home Office		558
				401K Match		3,274			
							Less: Public Relations Expense		(761)
							Non-allowable advertising		()
							Yellow page advertising		()
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 80,107	TOTAL (agree to Schedule V, line 22, col.8)		\$ 233,942	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 2,461
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fee (eliminated in column 7)			\$ 231,027	N/A			Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 231,027						
C. Professional Services									
Vendor/Payee	Type		Amount						
Bush, Snyder & Assoc.	Legal		\$ 507						
Altschuler, Melvoin & Glasser	Accounting		7,725						
American Expr. Tax & Bus. Svcs.	Accounting		3,100						
Kewanee.com	Computer services		375						
LTC Solutions	Computer services		1,320						
IVANS	Computer services		554						
ADP	Computer services		7,643						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 21,224	TOTAL		\$	Seminar Expense		710
							Allocated from Home Office		1,517
							Entertainment Expense		()
							(agree to Sch. V, line 24, col. 8)		
							TOTAL		\$ 2,227

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

Kewanee Care Home
Provider #: 0026518
01/01/04 to 12/31/04

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	21,224
Allocated from Management Company - Legal	2,048
Allocated from Management Company - Other	10,476
Total (agree to Schedule V, line 19, column 8)	<u>33,748</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

Amount of Expense Amortized Per Year													
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

<p>Facility Name & ID Number <u>Kewanee Care Home</u></p> <p>XX. GENERAL INFORMATION:</p> <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>No</u> If YES, give association name and amount. <u>N/A</u></p> <p>(3) Did the nursing home make political contributions or payments to a political organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? <u>N/A</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u></p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? <u>10 yrs</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>10,039</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over <u>N/A</u></p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ <u>46,116</u> This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p>	<p style="text-align: center;">STATE OF ILLINOIS</p> <p># <u>0026518</u> Report Period Beginning: <u>01/01/04</u> Ending: <u>12/31/04</u></p> <p>(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? <u>Yes</u></p> <p>(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>No</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ <u>N/A</u> Has any meal income been offset against related costs? <u>Yes</u> Indicate the amount. \$ <u>4,202</u></p> <p>(16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u> c. What percent of all travel expense relates to transportation of nurses and patients? <u>0</u> d. Have vehicle usage logs been maintained? <u>Adequate records have been maintained.</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>Yes</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u> g. Does the facility transport residents to and from day training? <u>NO</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>Yes</u> Firm Name: <u>Ginoli & Company</u> The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? <u>No</u> If no, please explain. <u>Audit currently in progress</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? <u>Yes</u> Attach invoices and a summary of services for all architect and appraisal fees.</p>
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SEE ACCOUNTANTS' COMPILATION REPORT

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	107,395	11,387	1,258	120,040	0	120,040	5,651	125,691
2. Food Purchase	0	125,509	0	125,509	0	125,509	-5,400	120,109
3. Housekeeping	65,899	8,500	0	74,399	0	74,399	24	74,423
4. Laundry	58,867	7,859	0	66,726	0	66,726	0	66,726
5. Heat and Other Utilities	0	0	73,521	73,521	0	73,521	513	74,034
6. Maintenance	37,781	39,862	2,514	80,157	0	80,157	3,529	83,686
7. Other (specify)*	0	0	0	0	0	0	1,011	1,011
8. Total General Services	269,942	193,117	77,293	540,352	0	540,352	5,328	545,680
9. Medical Director	0	0	10,100	10,100	0	10,100	0	10,100
10. Nursing & Medical Records	881,475	77,527	400	959,402	0	959,402	12,414	971,816
10a. Therapy	88,703	597	7,084	96,384	0	96,384	5	96,389
11. Activities	57,406	1,503	1,332	60,241	0	60,241	-1,327	58,914
12. Social Services	27,338	0	0	27,338	0	27,338	0	27,338
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	1,199	1,199
16. Total Health Care & Programs	1,054,922	79,627	18,916	1,153,465	0	1,153,465	12,291	1,165,756
17. Administrative	80,107	0	231,027	311,134	0	311,134	-161,692	149,442
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	21,224	21,224	0	21,224	12,524	33,748
20. Fees, Subscriptions & Promotion	0	0	2,664	2,664	0	2,664	-203	2,461
21. Clerical & General Office	20,225	7,755	14,841	42,821	0	42,821	42,194	85,015
22. Employee Benefits & Payroll	0	0	233,942	233,942	0	233,942	0	233,942
23. Inservice Training & Education	0	0	5,763	5,763	0	5,763	714	6,477
24. Travel and Seminar	0	0	710	710	0	710	1,517	2,227
25. Other Admin. Staff Trans	0	0	9,956	9,956	0	9,956	2,915	12,871
26. Insurance-Prop.Liab.Malpractice	0	0	54,300	54,300	0	54,300	1,020	55,320
27. Other (specify)*	0	0	0	0	0	0	11,761	11,761
28. Total General Adminis	100,332	7,755	574,427	682,514	0	682,514	-89,250	593,264
29. Total General Administrative	1,425,196	280,499	670,636	2,376,331	0	2,376,331	-71,631	2,304,700
30. Depreciation	0	0	82,784	82,784	0	82,784	19,491	102,275
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	134,449	134,449	0	134,449	5,739	140,188
33. Real Estate	0	0	32,680	32,680	0	32,680	375	33,055
34. Rent - Facility & Grounds	0	0	0	0	0	0	2,925	2,925
35. Rent - Equipment & Vehicles	0	0	1,728	1,728	0	1,728	102	1,830
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	251,641	251,641	0	251,641	28,632	280,273
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	57,835	0	57,835	0	57,835	0	57,835
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	46,116	46,116	0	46,116	0	46,116
43. Other (specify):*	0	0	36,062	36,062	0	36,062	-36,062	0
44. Total Special Cost Ce	0	57,835	82,178	140,013	0	140,013	-36,062	103,951
45. Grand Total	1,425,196	338,334	1,004,455	2,767,985	0	2,767,985	-79,061	2,688,924

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	6,334,340	6,334,340
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	427,549	427,549
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	3,424	3,424
8. Accounts Receivable-Owner/Related Party	-4,690	-4,690
9. Other (specify):	961,855	961,855
10. Total current assets	7,722,478	7,722,478
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	151,595	50,621
14. Buildings, at Historical Cost	2,095,231	2,189,371
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	510,963	476,688
17. Accumulated Depreciation (book methods)	-1,090,417	-987,516
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	1,667,372	1,729,164
25. Total Assets	9,389,850	9,451,642
CURRENT LIABILITIES		
26. Accounts Payable	3,475,147	3,475,147
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	64,500	64,500
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	21,100	21,100
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	71,554	71,554
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	3,632,301	3,632,301
LONG TERM LIABILITES		
39. Long-Term Notes Payable	21,709	21,709
40. Mortgage Payable	2,802,986	2,802,986
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	2,824,695	2,824,695
46. Total Liabilities	6,456,996	6,456,996
47. Total Equity	2,932,854	2,994,646
48. Total Liabilities and Equity	9,389,850	9,451,642

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,620,353
2. Discounts and Allowances for all Levels	10,227
Subtotal - Inpatient Care	2,630,580
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	429,518
7. Oxygen	0
Subtotal - Ancillary Revenue	429,518
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	4,202
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	142,571
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	97,225
22. Laundry	0
Subtotal - Other Operating Revenue	243,998
24. Contributions	0
25. Interest and Other Investments Income	33
Subtotal - Non-Operating Revenue	33
27. Other Revenue (specify):	8,245
28. Other Revenue (specify):	0
Subtotal - Other Revenue	8,245
30. Total Revenue	3,312,374
31. General Services	540,352
32. Health Care	1,153,465
33. General Administration	682,514
34. Ownership	251,641
35. Special Cost Centers	93,897
35. Provider Participation Fee	46,116
37. Other	0
40. Total Expenses	2,767,985
41. Income Before Income Taxes	544,389
42. Income Taxes	0
43. Net Income or Loss for the Year	544,389

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